

PCH/CLA TRAINING REGISTRATION FORM

(NOTE: Use one form for each **DATE** of training.)

NAME OF TRAINING SESSION: _____

DATE OF TRAINING SESSION: _____

Please note that the New Provider's Training fills up quickly. If the class listed above is filled, and you would like to be scheduled for the next available class, please indicate below:

☐ Yes, schedule me for the next available class.

☐ No, do not schedule me for the next available class. Please schedule me for the class on the following date: _____

☐ No, do not schedule me for any classes and return my check to me.

FROM: (Organization) _____

(Address) _____

Tel. No.) _____

(Fax No.) _____

(E-mail Address) _____

Print below the names and titles of individuals attending the training on the above date as you wish it to appear on certificates:

(Name & Title) _____

(Name & Title) _____

(Name & Title) _____

(Name & Title) _____

(Name & Title) _____

(Name & Title) _____

(Name & Title) _____